

## I. STATE/LOCAL USE ONLY

Patient's Name: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_  
 (Last, First, M.I.)  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
**RETURN TO STATE/LOCAL HEALTH DEPARTMENT** - Patient identifier information is not transmitted to CDC! -

U.S. DEPARTMENT OF HEALTH  
& HUMAN SERVICES  
Centers for Disease Control  
and Prevention

## PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT

(Patients <13 years of age at time of diagnosis)



## DATE FORM COMPLETED:

## II. HEALTH DEPARTMENT USE ONLY

Form Approved OMB No. 0920-0009

<b>REPORT SOURCE:</b> <input type="checkbox"/> <input type="checkbox"/>	<b>SOUNDEX CODE:</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>REPORT STATUS:</b> <input type="checkbox"/> New Report <input type="checkbox"/> Update	<b>REPORTING HEALTH DEPARTMENT:</b> State: _____ City/County: _____	<b>State Patient No.:</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>City/County Patient No.:</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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## III. DEMOGRAPHIC INFORMATION

<b>DIAGNOSTIC STATUS AT REPORT:</b> (check one) <input type="checkbox"/> Perinatally HIV Exposed <input type="checkbox"/> Confirmed HIV Infection (not AIDS) <input type="checkbox"/> AIDS <input type="checkbox"/> Seroreverter		<b>DATE OF LAST MEDICAL EVALUATION:</b> Mo. <input type="text"/> Yr. <input type="text"/>	
<b>DATE OF BIRTH:</b> Mo. <input type="text"/> Day <input type="text"/> Yr. <input type="text"/>	<b>AGE AT DIAGNOSIS:</b> HIV Infection (not AIDS) ... Years <input type="text"/> Months <input type="text"/> AIDS ..... Years <input type="text"/> Months <input type="text"/>	<b>CURRENT STATUS:</b> <input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unk.	<b>DATE OF DEATH:</b> Mo. <input type="text"/> Day <input type="text"/> Yr. <input type="text"/>
<b>Was reason for initial HIV evaluation due to clinical signs and symptoms?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>		<b>SEX:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>RACE/ETHNICITY:</b> <input type="checkbox"/> White (not Hispanic) <input type="checkbox"/> Black (not Hispanic) <input type="checkbox"/> Hispanic		<b>COUNTRY OF BIRTH:</b> <input type="checkbox"/> U.S. <input type="checkbox"/> U.S. Dependencies and Possessions (including Puerto Rico) (specify): _____ <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unk.	
<b>RESIDENCE AT DIAGNOSIS:</b> City: _____ County: _____ State/Country: _____ Zip Code: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			

## IV. FACILITY OF DIAGNOSIS

Facility Name: _____ City: _____ State/Country: _____	
<b>FACILITY SETTING</b> (check one) <input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Federal <input type="checkbox"/> Unk.	<b>FACILITY TYPE</b> (check one) <input type="checkbox"/> Physician, HMO <input type="checkbox"/> Hospital, Inpatient <input type="checkbox"/> Other (specify): _____

## V. PATIENT/MATERNAL HISTORY (Respond to ALL categories)

<b>• Child's biologic mother's HIV Infection Status:</b> (check one) <input type="checkbox"/> Refused HIV testing <input type="checkbox"/> Known to be <u>un</u> infected after this child's birth <input type="checkbox"/> HIV status unknown Diagnosed with HIV Infection/AIDS: <input type="checkbox"/> Before this child's pregnancy <input type="checkbox"/> At time of delivery <input type="checkbox"/> After the child's birth <input type="checkbox"/> During this child's pregnancy <input type="checkbox"/> Before child's birth, exact period unknown <input type="checkbox"/> HIV-infected, unknown when diagnosed		<b>• Date of mother's first positive HIV confirmatory test:</b> Mo. <input type="text"/> Yr. <input type="text"/> <b>• Mother was counseled about HIV testing during this pregnancy, labor or delivery?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>	
<b>After 1977, this child's biologic mother had:</b> • Injected nonprescription drugs ..... Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/> • <b>HETEROSEXUAL</b> relations with: - Intravenous/injection drug user ..... Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/> - Bisexual male ..... Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/> - Male with hemophilia/coagulation disorder ..... Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/> - Transfusion recipient with documented HIV infection ..... Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/> - Transplant recipient with documented HIV infection ..... Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/> - Male with AIDS or documented HIV infection, risk not specified ..... Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/> • Received transfusion of blood/blood components (other than clotting factor) ..... Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/> • Received transplant of tissue/organs or artificial insemination ..... Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>		<b>Before the diagnosis of HIV Infection/AIDS, this child had:</b> • Received clotting factor for hemophilia/coagulation disorder ..... Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/> (specify: <input type="checkbox"/> Factor VIII (Hemophilia A) <input type="checkbox"/> Factor IX (Hemophilia B) disorder): <input type="checkbox"/> Other (specify): _____ • Received transfusion of blood/blood components (other than clotting factor) ..... Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/> First: Mo. <input type="text"/> Yr. <input type="text"/> Last: Mo. <input type="text"/> Yr. <input type="text"/> • Received transplant of tissue/organs ..... Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/> • Sexual contact with a male ..... Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/> • Sexual contact with a female ..... Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/> • Injected nonprescription drugs ..... Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/> • Other (Alert State/City NIR Coordinator) ..... Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>	

**VI. STATE/LOCAL USE ONLY**

Physician's Name: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_ Medical Record No. \_\_\_\_\_  
(Last, First, M.I.)

Hospital/Facility: \_\_\_\_\_ Person Completing Form: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_  
- Physician identifier information is not transmitted to CDC! -

**VII. LABORATORY DATA**
**1. HIV ANTIBODY TESTS AT DIAGNOSIS:** (Record all tests, include earliest positive)

	Positive	Negative	Indeterminate	Not Done	TEST DATE Mo. Yr.
• HIV-1 EIA .....	1	0	-	9	
• HIV-1 EIA .....	1	0	-	9	
• HIV-1/HIV-2 combination EIA .....	1	0	-	9	
• HIV-1/HIV-2 combination EIA .....	1	0	-	9	
• HIV-1 Western blot/IFA .....	1	0	8	9	
• HIV-1 Western blot/IFA .....	1	0	8	9	
• Other HIV antibody test (specify): .....	1	0	8	9	

**2. HIV DETECTION TESTS:**

(Record all tests, include earliest positive)

	Positive	Negative	Not Done	TEST DATE Mo. Yr.
• HIV culture .....	1	0	9	
• HIV culture .....	1	0	9	
• HIV antigen test .....	1	0	9	
• HIV antigen test .....	1	0	9	

	Positive	Negative	Not Done	TEST DATE Mo. Yr.
• HIV DNA PCR .....	1	0	9	
• HIV DNA PCR .....	1	0	9	
• HIV RNA PCR .....	1	0	9	
• HIV RNA PCR .....	1	0	9	
• Other, specify .....	1	0	9	

**3. HIV VIRAL LOAD TEST:** (Record all tests, include earliest detectable)

\*Type: 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA(Chiron) 18. Other

Test type*	Detectable Yes No	Copies/ml	Test Date Mo. Yr.
	1 0		

Test type*	Detectable Yes No	Copies/ml	Test Date Mo. Yr.
	1 0		

**4. IMMUNOLOGIC LAB TESTS:** (At or closest to current diagnostic status)

	Mo.	Yr.
• CD4 Count .....		
• CD4 Count .....		
• CD4 Percent .....		
• CD4 Percent .....		

5. If HIV tests were not positive or were not done, or the patient is less than 18 months of age, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition? Yes No Unk. 1 0 9

6. If laboratory tests were not documented, is patient confirmed by a physician as: Yes No Unk. 1 0 9  
• HIV-infected .....  
• Not HIV-infected .....

**VIII. CLINICAL STATUS**

AIDS INDICATOR DISEASES	Initial Diagnosis Def. Pres.	Initial Date Mo. Yr.
Bacterial infections, multiple or recurrent (including Salmonella septicemia)	1 NA	
Candidiasis, bronchi, trachea, or lungs	1 NA	
Candidiasis, esophageal	1 2	
Coccidioidomycosis, disseminated or extrapulmonary	1 NA	
Cryptococcosis, extrapulmonary	1 NA	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	1 NA	
Cytomegalovirus disease (other than in liver, spleen, or nodes) onset at >1 mo. of age	1 NA	
Cytomegalovirus retinitis (with loss of vision)	1 2	
HIV encephalopathy	1 NA	
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis, onset at >1 mo. of age	1 NA	
Histoplasmosis, disseminated or extrapulmonary	1 NA	
Isosporiasis, chronic intestinal (>1 mo. duration)	1 NA	

AIDS INDICATOR DISEASES	Initial Diagnosis Def. Pres.	Initial Date Mo. Yr.
Kaposi's sarcoma	1 2	
Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia	1 2	
Lymphoma, Burkitt's (or equivalent term)	1 NA	
Lymphoma, immunoblastic (or equivalent term)	1 NA	
Lymphoma, primary in brain	1 NA	
Mycobacterium avium complex or M.kansasii, disseminated or extrapulmonary	1 2	
M. tuberculosis, disseminated or extrapulmonary*	1 2	
Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	1 2	
Pneumocystis carinii pneumonia	1 2	
Progressive multifocal leukoencephalopathy	1 NA	
Toxoplasmosis of brain, onset at >1 mo. of age	1 2	
Wasting syndrome due to HIV	1 NA	

Def. = definitive diagnosis Pres. = presumptive diagnosis

Has this child been diagnosed with pulmonary tuberculosis?\* 1 Yes 0 No 9 Unk. If yes, initial diagnosis and date: 1 Definitive 2 Presumptive Mo. Yr. \*RVCT CASE NO.:

# IX. BIRTH HISTORY (for PERINATAL cases only)

Birth history was available for this child: ☐ Yes ☐ No ☐ Unk. *If No or Unknown, proceed to Section X.*

## HOSPITAL AT BIRTH:

Hospital: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

## RESIDENCE AT BIRTH:

City: \_\_\_\_\_ County: \_\_\_\_\_ State/Country: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## BIRTHWEIGHT:

(enter lbs/oz OR grams)

\_\_\_\_ lbs. \_\_\_\_ oz

\_\_\_\_ grams

## BIRTH:

Type: .... ☐ Single ☐ Twin ☐ >2 ☐ Unk.

Delivery: ..... ☐ Vaginal ☐ Elective Caesarean ☐ Non-elective Caesarean  
☐ Caesarean, unk. type ☐ Unk.

Birth Defects: .... ☐ Yes ☐ No ☐ Unk.

Specify type(s): \_\_\_\_\_ Code: \_\_\_\_\_

## NEONATAL STATUS:

☐ Full term  
☐ Premature

Weeks \_\_\_\_\_  
99 = Unk.

## PRENATAL CARE:

Month of pregnancy prenatal care began: \_\_\_\_\_ mos.  
99 = Unk.  
00 = None

Total number of prenatal care visits: \_\_\_\_\_  
99 = Unk.  
00 = None

• Did mother receive zidovudine (ZDV, AZT) during pregnancy? Refused Yes No Unk.  
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

• Did mother receive zidovudine (ZDV, AZT) during labor/delivery? Refused Yes No Unk.  
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

• If yes, what week of pregnancy was zidovudine (ZDV, AZT) started? Weeks: \_\_\_\_\_  
99 = Unk.

• Did mother receive zidovudine (ZDV, AZT) prior to this pregnancy? Yes No Unk.  
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

• Did mother receive any other Anti-retroviral medication during pregnancy? Yes No Unk.  
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

If yes, specify: \_\_\_\_\_

• Did mother receive any other Anti-retroviral medication during labor/delivery? Yes No Unk.  
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

If yes, specify: \_\_\_\_\_

## Maternal Date of Birth

Mo. Day Yr.  
\_\_\_\_

## Maternal Surname:

\_\_\_\_

## Maternal State Patient No.

\_\_\_\_

## Birthplace of Biologic Mother:

☐ U.S. ☐ U.S. Dependencies and Possessions (including Puerto Rico) (specify): \_\_\_\_\_  
☐ Other (specify): \_\_\_\_\_ ☐ Unk.

# X. TREATMENT/SERVICES REFERRALS

## This child received or is receiving:

• Neonatal zidovudine (ZDV, AZT) for HIV prevention Yes No Unk. DATE STARTED Mo. Day Yr.  
☐ ☐ ☐ \_\_\_\_\_

• Other neonatal anti-retroviral medication for HIV prevention Yes No Unk. DATE STARTED Mo. Day Yr.  
☐ ☐ ☐ \_\_\_\_\_

If yes, specify: \_\_\_\_\_

• Anti-retroviral therapy for HIV treatment Yes No Unk. DATE STARTED Mo. Day Yr.  
☐ ☐ ☐ \_\_\_\_\_

• PCP prophylaxis Yes No Unk. DATE STARTED Mo. Day Yr.  
☐ ☐ ☐ \_\_\_\_\_

## Was child breastfed?

Yes No Unk. .  
☐ ☐ ☐

## This child has been enrolled at:

Clinical Trial Clinic  
☐ NIH-sponsored ☐ Other ☐ HRSA-sponsored ☐ Other  
☐ None ☐ Unk. ☐ None ☐ Unk.

## This child's medical treatment is primarily reimbursed by:

☐ Medicaid ☐ Other Public Funding  
☐ Private insurance/HMO ☐ Clinical trial/government program  
☐ No coverage ☐ Unk.

## This child's primary caretaker is:

☐ Biologic parent(s) ☐ Other relative ☐ Foster/Adoptive parent, relative ☐ Foster/Adoptive parent, unrelated ☐ Social service agency ☐ Other (specify in Section XI.) ☐ Unk.

# XI. COMMENTS:

(XI. COMMENTS CONTINUED ON THE BACK)

This report to the Centers for Disease Control and Prevention (CDC) is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of HIV/AIDS. Information in CDC's HIV/AIDS surveillance system that would permit identification of any individual on whom a record is maintained, is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on file at the local health department, and will not otherwise be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0009). Do not send the completed form to this address.

## XI. COMMENTS (continued)

This image shows a blank sheet of white paper with horizontal blue or grey ruling lines. A single vertical dashed line runs down the left side of the page, creating a margin. The lines are evenly spaced and extend across the width of the page. There is no handwriting or other markings on the paper.